MDR Tracking Number: M5-04-3592-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 06-21-04. .

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor prevailed** on the majority of the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

The following service was previously paid in accordance with the Medicare program reimbursement methodology and therefore will not be considered in this review:
CPT code L3908 for date of service 10/15/03.

The IRO reviewed office visits (with and without manipulation), joint mobilization, myofascial release, therapeutic exercises, manual therapy techniques, ultrasound therapy, electrical stimulation, hot/cold packs therapy, mechanical traction, physical performance test, and chiropractic manipulative treatment rendered from 7/01/03 to 10/15/03 that were denied based upon “V.”

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The office visits and treatments/services outlined above and rendered from 7/1/03 through 7/16/03, and the office visits and treatments/services outlined above rendered on 8/19/03 and 10/15/03 **were found** to be medically necessary. The office visits and treatments/services outlined above and rendered on 7/21/03, 7/22/03 and 8/4/03 **were not found** to be medically necessary.

The respondent raised no other reasons for denying reimbursement for the above listed services.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees outlined above as follows:

- in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003;

- in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (b);

- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order.

This Order is applicable to dates of service 7/1/03 through 10/15/03 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 28th day of September 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division
RLC/rlc

August 24, 2004

Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

REVISED REPORT
Corrected dates of service.

Re: Medical Dispute Resolution
MDR #: M5-04-3592-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.:

Dear

___has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:
TWCC-60, Table of Disputed Services, EOB's
Information provided by Requestor: consultations and office visits, treatment logs, PPE and treatment notes.

Clinical History:
The claimant was injured at work on ___. She was diagnosed with a right shoulder rotator cuff tendonitis, right lateral elbow epicondylitis, carpal tunnel syndrome, and d' Quervain's tenosynovitis. She has undergone conservative care consisting of cortisone injections, wrist brace, and chiropractic rehab. She continues to perform her normal duties at work, which consists of daily data entry.

Disputed Services:
Office visits, office visits w/manipulation, joint mobilization, myofascial release, ultrasound therapy, electrical stimulation, manual therapy, hot/cold pack therapy, mechanical traction, therapeutic exercises, physical performance testing-muscle, and CMT 1-2 regions during the period of 07/01/03 through 10/15/03.

Decision:
The reviewer partially agrees with the determination of the insurance carrier as follows:

Medically Necessary:
- office visits and treatment/services rendered during the period of 07/01/03 and 07/16/03
- office visits & treatment/services on August 19, 2003 and October 15, 2003.

Not Medically Necessary:
- office visits & treatment/services on 07/21, 07/22 & 08/04/2003.

Rationale:
The claimant's date of injury and history indicates that she can be classified as a chronic complicated case based on the Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters, page 125. Her symptoms have been prolonged beyond 16 weeks. According to the guidelines, supervised rehab and lifestyle changes are appropriate. She may not be able to return to pre-injury status, and supportive care using passive therapy should only be done if repeated efforts to withdraw treatment or care resulted in significant deterioration of her clinical status.

According to the evaluation performed on July 1, 2003, the claimant has been experiencing pain and difficulty in the right upper extremity intermittently over the last 6 months. He examining doctor noted no new exacerbation or re-injury.

Based solely on the guidelines and the documentation provided, the claimant is entitled to care based on the medical necessity and appropriateness of the situation. However, at this point, active in office rehab is not medically necessary. Exercises can be done at home and monitored by the doctor. Passive care should be limited to controlling the pain levels. According to the Texas Guidelines a maximum of two weeks of therapy should be performed before alternative care is considered, chapter 8 page 124.

Therefore, office visits and treatments/services between July 2, 2003 and July 16, 2003 can be considered medically necessary and appropriate. Following this date, it is medically necessary for the treating doctor to remain up to date on his patient's condition. Therefore, one office visit per month, unless the condition changed, would be prudent. Therefore, office visits dated August 19, 2003 and October 15, 2003 can be considered medically necessary and appropriate. The dates of July 21st, July 23rd, and August 4th of 2003, were not medically necessary or appropriate.